also deplores the domestic manufacture of tobacco products for export.

Dr. Finlayson's letter touches on an interesting issue in clinical practice. CMA recommends that tobacco-intervention programs be created specifically for populations at risk; this recommendation would cover all populations, not just the ones mentioned by name in the policy summary. We certainly acknowledge that patients receiving psychiatric care and people with addictions are populations at risk (and, in fact, many also belong to other at-risk populations), although policy-makers such as governments do not tend to consider them a high-priority group. However, as Finlayson points out, there is disagreement within the profession as to the appropriate method of dealing with tobacco use among patients receiving psychiatric care and people with addictions. Finlayson's letter contributes valuable evidence to the debate, and we welcome his input. We will follow this issue with interest in coming years.

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Can we finally change the system?

I am forced to comment on the articles "What are the facts concerning the number of residency positions in Canada?" (*Can Med Assoc J* 1997;156: 665-7), by Dr. Dale Dauphinee and Dianne Thurber, and "Little room for error in Canada's postgraduate training system" (*Can Med Assoc J* 1997; 156:682-4), by Sandy Robertson.

I am one of the "lucky ones" who was able to find a residency in the specialty of my choice after first serving as a general practitioner in an underserviced part of Ontario for 5 years. I am now in my third year at the Medical College of Wisconsin in Milwaukee.

I commend *CMAJ* for publishing these 2 articles and for drawing some attention to this topic. However, I am hurt by Dr. John Hoey's comments in the Editor's preface, which imply that things are not as bad as they seem. If he is having trouble understanding this issue, then I assume others are having the same problem.

In their article, Dauphinee and Thurber fail to mention the number of first-year residency positions. I would like to know how the "re-entry trainees (Canadian graduates)" positions are defined. They give figures of 632 in 1993 and 489 in 1994. When I applied in those years, there were none. Finally, I find no comfort in their concluding statement that "they [physicians] can still get training, but it may not be the training they want." Is this what we — physicians and future patients — want?

I am glad that Sandy Robertson gave us the truth: "No subject is more fraught with anger and frustration than their [Canadian physicians] current inability to enter a new post-

Physician fees: tale of 2 countries

The article "MD fees much higher in US" (*Can Med Assoc J* 1997;156:960) included a table that detailed some of the discrepancies in medical fees between the US and Canada. However, author Lynda Buske did not include the specialty of diagnostic imaging. I am well aware of gross differences between the 2 countries in fees for our specialty as well. This article prompted me to contact a colleague who graduated from a Canadian residency program at the same time as I did and now works in Charleston, Ill. From information supplied by my colleague and from the 1992 fee schedule of the Ontario Health Insurance Plan, I have pieced together an addendum to the table (Table 1).

Once again, the numbers reveal what an incredible bargain the Ontario Ministry of Health is getting from the physicians of Ontario; in this case, Ontario radiologists.

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Table 1: US and Canadian physician fees for selected diagnostic imaging procedures

Procedure	US fee, converted to Can$: Minimum (Medicare)	Maximum (private insurance)	Median (minimum + maximum/2)	OHIP* fee 1992–present
Chest radiograph	13.60	54.40	34.00	8.80
Mammogram	NA†	68.00	68.00	20.20
Needle localization for lumpectomy	87.04	272.00	179.52	46.50
Nuclear-medicine ventilation–perfusion scan	51.68	217.60	134.64	50.35
MRI scan of the lumbar spine	91.12	394.40	242.76	96.35
CT scan of the head with and without contrast agent	77.52	353.60	215.56	71.90
Obstetric ultrasonographic scan				
Uncomplicated	47.60	217.60	132.60	29.10
Multiple gestation	121.04	400.08	260.56	29.10
Biophysical profile	47.60	217.60	132.60	0
Cord Doppler analysis	5.44	171.36	88.40	0

*OHIP = Ontario Health Insurance Plan.
†NA = not available.

graduate-training program. . . . Some see it as a tragedy, but if it is, it is a tragedy without a villain." I submit that those who have tightened the purse strings without consideration of the ensuing hardships are potential candidates for that label.

Robertson later states, regarding physicians who chose to practise before entering a specialty, that "today that option does not exist, and those who were in practice before the system changed have found that most training posts are reserved for new graduates. Finding a retraining position in another specialty is difficult, if not impossible." I assume that Robertson knows that no positions are available in Canada and that she is referring to those of us who have left our native land, family and friends, and have moved to the US.

It is intolerable that we have allowed this situation to develop. I hope that the motion passed at the CMA's 1996 annual meeting — that "the CMA should convene a national meeting to address the crisis in postgraduate medical education" — is not forgotten, and that physicians make this issue a priority. Special thanks to the British Columbia Medical Association for this long overdue motion.

Can we finally change the system?

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Dauphinee and Thurber acknowledge that major changes have occurred in "physician-resource policies and medical-licensing requirements in Canada." It is also true that "discussions and decisions based on valid facts" are critically important. Unfortunately, their "facts" related to re-entry positions are grossly misleading. Currently, few re-entry positions are available in Canada. A recent national meeting noted that only 7 unlimited re-entry positions were available in Canada (1 in BC, 2 in Newfoundland and 4 in Nova Scotia). Ontario has 24 re-entry positions with "return-of-service" clauses. Manitoba, Saskatchewan, Alberta and Quebec have no formal re-entry positions. Some 1-year positions are available for GP/FPs, and other re-entry positions become available when residency positions go unmatched. The current limited number of positions available should be cause for concern, particularly in a province such as Manitoba, where 20% of specialists have taken the re-entry route.

Medical students are forced to decide which aspect of medicine to pursue far too early in their training. Who wants to be cared for by an uninterested or depressed physician or surgeon? Why is it so difficult to attract Canadian graduates to rural medicine? Is it possible that trainees think rural or remote practice will lock them out of the cities or specialties for the rest of their lives? Easy access to re-entry positions for GP/FPs who choose to practise and learn more about medicine and themselves in a rural or remote setting may help correct our physician distribution problems. The time I spent as a "country doc" before turning to specialty training benefited me, my patients and my communities, past and present. It gave me a view of medicine from beyond the "ivory tower," and I would urge the Medical Council of Canada and the Canadian Post-MD Education Registry, training programs and credentialling bodies to share it.

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I was pleased to see the 2 articles on residency positions in Canada. We are now witnessing a failed experiment in medical education. Every clinician and student I have talked to feels that the loss of the rotating internship has been detrimental. Rather than having a common year of training for physicians who will become GPs or specialists, medical students must now make a forced and irrevocable choice during their third year in medical school. In many cases they have to make a lasting commitment to a clinical specialty before they have even experienced it.

I disagree with Dauphinee and Thurber's statement that "future demands for these [re-entry] positions will decrease since all of today's graduates will have completed their specialty training before being licensed." In fact, the opposite is true. Many physicians are uncertain about their future specialty training. Because of this, many have gone into general or family practice to experience real-life practice. After 3 to 5 years they may, sensibly, make a choice for further specialty training. Currently, these physicians are completely locked out of the system. In retrospect, the error was that additional demands were placed on the system — a second year of training for all family practice trainees — without any commitment from government to supply additional training positions.

I was surprised to read that Sandra Banner believes there is flexibility in the system and that more than 200 successful switches were made from one training program to another in 1996. This has certainly not been the case in BC.

It is distressing to learn that the College of Family Physicians of Canada is now "allowing additional training for extended roles in family medicine." This is well and good, but, unless additional positions are available, it will worsen existing problems.

As directed by General Council, the CMA is hosting a conference on the crisis in postgraduate medical education, and I believe some consensus will emerge. Still, the training system in place today is inferior to the one I trained in 20 years ago. We need to reinstate the rotating internship and lobby to have additional training positions so there is some flexibility in the system. There is an acute need for more re-entry positions, and we certainly should not add any more training requirements without a firm commitment for additional training spots. All CMA members should lobby our national medical associations so that a solution can be developed quickly.

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The size and makeup of the postgraduate training system is determined by 3 main factors: the number of training positions, the number of entrants and the training ratio of family physicians to specialists. The number of training positions must respond to the other 2 factors, rather than being the fixed or primary determinant. As Dauphinee and Thurber note, changes in the training (practice) ratio have a significant impact on the number of postgraduate positions required.

The formal education continuum begins with entry into medical school and ends with licensure and entry into practice. It is not productive, or, arguably, morally justified, to deny undergraduates an opportunity to move into the postgraduate component and, eventually, medical practice.

Provincial ministries of health are concerned about the immediate cost of the postgraduate positions they fund and look to further reductions to save money. They will need to provide, at a minimum, financial support for the postgraduate training of graduates of Canadian medical schools if they want to ensure that the medical education continuum is realized for both individuals and society. Some argue against graduates of Canadian schools being guaranteed postgraduate training in Canada; graduates of other professional schools enjoy no such guarantee. This argument denies the reality of the medical education continuum, artificially splits it into the undergraduate and postgraduate phases and overlooks the fact that medical graduates cannot be licensed and enter practice without a prescribed period of postgraduate training, available only through accredited educational programs that are funded mainly by government. Therefore, if governments continue to regulate and fund postgraduate medical education, they must also preserve the integrity of the education continuum and provide sufficient flexibility to permit extra preparation for academic careers, rural and remote practice, remediation and re-entry of practising physicians.

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I continue to be appalled that medical students must decide what postgraduate program they are going to pursue around the end of their second undergraduate year. In many cases this is almost impossible because their experience and exposure to medicine are far too limited. It is even sadder that once a course of action has been chosen, the young physician's future is written in stone.

I am eager to enter this fray because of the article "Little room for error in Canada's postgraduate training system" by Sandy Robertson. I was invited to train in surgery because the late Angus D. McLachlin caught me working on a public surgical ward as a junior intern. Of course, that latter post no longer exists. My happy 35 years doing pediatric surgery could not have happened under present rules and conditions.

The junior internship year was the most valuable year of my medical life. According to Robertson, this training year was abolished by the demands of the College of Family Physicians of Canada. It is serious and very sad that only rarely can physicians change their course of action, although it appears that some have made career changes. As well, some provinces are trying to improve things. A Mar. 3, 1997, bulletin from the Ontario Ministry of Health[1] refers to re-entry opportunities for 10 Ontario general/family physicians, who will be able to pursue advanced skills in emergency medicine, anesthesia or geriatrics. There are also 15 re-entry specialty positions available in general surgery, obstetrics, general internal medicine and psychiatry. The snag — and of course there is one — is that these people must return to practice in an underserviced area. This is to start July 1, 1997.

If deans of medicine would consider this problem, perhaps changes could be made. A few days ago, an internist told me he has never before seen the high level of anxiety found in today's medical students. The demand that they make too early a career choice is a big factor in this.

I hope that this article will be read, thought about and acted upon for the good of our medical students and future trainees.

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Reference

1. Ontario Ministry of Health. Re-entry opportunities for Ontario general/family physicians [letter]. Ontario: The Ministry; 1997.

[Dr. Dauphinee and Ms. Thurber respond:]

Along with Drs. Becker and Smith, we are sensitive to the plight of the post-1989 medical school graduates who have been charting their careers in the midst of a tangle of changing regulations. This transition period put a virtual stop to the option of re-entry because all existing government-funded positions were filled by the new graduates completing the requirements for certification and licensure. The number of re-entry trainees was the number of all trainees who had previously been in practice. This number decreased by 40% between 1988 and 1995 because no new re-entry trainees were admitted to replace those who had completed and left training. Smith notes our oversimplification that all current graduates will have completed specialty training before licensure. His point is well taken. We recognize a continuing need for re-entry training of our current graduates and the significance of this option for specialties such as psychiatry, community medicine and laboratory medicine, which have obtained many of their physicians through re-entry.

Dr. Narini is obviously 1 of many physicians victimized by the situation that our data describe. Unfortunately, his letter implies that our figures fail to validate his experience. On the contrary, our data confirm his personal experience and explain why it happened.

Because those involved in funding postgraduate training realize that a physician who re-enters training will not result in a new addition to the total practice pool, we expect that in the future training positions will become available for more practising physicians. The decreased number of new Canadian graduates who will start training in July 1997 and the impending retirement of specialists, who form our oldest category of physicians, mean that space in training should become available for practising physicians who are seeking further specialty training.

We are surprised by some of the reaction to our article. The accompanying Editor's preface may have inadvertently set the stage by suggesting that things are not as bad as they seem. In our view, the opportunity for re-entry to postgraduate training will improve only if sufficient re-entry positions are supported by governments in a time of restraint and if the profession and organized medicine support the need for these positions. If provincial ministries cut the number of entry positions to only those needed for graduating students, a key opportunity to avoid the experiences of Narini and others like him will be lost.

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Furious about the forum

I am greatly distressed that *CMAJ* has given Dr. Mamoru Watanabe a platform from which to speak on behalf of the National Forum on Health ("A call for action from the National Forum on Health," *Can Med Assoc J* 1997;156:999-1000).

Although it is well within the realm of public policy to decide what percentage of the gross domestic product from public monies should be spent on health care, it is unacceptable and intrusive for government to decide how much of their own money individual citizens can or should pay for health care or anything else. This fundamental flaw in our public policy was never even addressed by the forum, even though more than 28% of all money spent on health care in Canada involves private-sector spending.

The forum has apparently failed to notice the remarkable strife that has arisen at the provincial level, largely because the federal government has withdrawn billions of dollars in funding. The results include growing waiting lists, unemployed nurses and angry confrontations between physicians and provincial governments. Considering this, I am astounded that Watanabe concluded: "We must expand publicly funded services to include all medically necessary services." He added that "the evidence suggests that increasing the scope of public expenditure may be the key to reducing total costs." I am not an economist, but it is absolutely preposterous to propose that, in the face of massive federal cutbacks, the scope of public expenditures be increased.

I concur entirely with the support for more focused spending on children's health, particularly for children living in poverty, and a commitment to evidence-based medicine. Overall, however, the National Forum failed to bring any new thinking to the very real fiscal problems facing medicare in Canada. The forum may have served its Liberal masters well, but it failed to address or even acknowledge the serious problems front-line clinicians witness every day.

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